Pre-Exposure Prophylaxis Drug Assistance Program (PrEP DAP)
Agreement, Release of Information & Assignment of Benefits

DOH 150-103 May 2017

SECTION 5: Agreement, Release of Information & Assignment of Benefits

Eligibility:

To be eligible for PrEP DAP, you must meet certain conditions. Please check the boxes that best describe your current risk for HIV-1 infection. I am a person who:

☐ **Is male or transgender who has sex with men and has one or more of the following risks:** (Check all that apply)
- ☐ Diagnosis of rectal or urethral gonorrhea, rectal chlamydia or early syphilis in the prior 12 months
- ☐ Methamphetamine or popper use in the prior 12 months
- ☐ History of providing sex for money, drugs, food, shelter or transportation in the prior 12 months
- ☐ Unprotected anal sex outside of a long-term, mutually monogamous relationship

☐ **Is in an ongoing sexual relationship with an HIV-infected person who:**
- ☐ Is not on antiretroviral therapy (ART)
- ☐ Is on ART but is not virologically suppressed
- ☐ Is within 6 months of initiating ART
- ☐ Is on ART and is virologically suppressed

☐ **Is in an ongoing sexual relationship in which the female partner is trying to get pregnant**
☐ **Is a woman who provides sex for money, drugs, food, shelter or transportation**
☐ **Injects drugs that are not prescribed by a medical provider**

Agreement:

I am applying for services (coverage of TRUVADA®) from the PrEP Drug Assistance Program (PrEP DAP). By signing at the end of this section, I state that I have read and understand this application and agree to the following:

I have a right to:
- Be treated with respect, consideration and honesty.
- Receive PrEP DAP services without discrimination on the basis on race, color, sex/gender, ethnicity, national origin, religion, age, class, sexual orientation or physical or mental ability.
- Have my records protected and treated confidentially.
- File an appeal about eligibility and coverage decisions.

I have the responsibility to:
- Treat PrEP DAP staff with respect, consideration and honesty.
- Give true, correct and complete information.
- Adhere to medically recommended testing and treatment, including all activities recommended in current PrEP standards of practice.

I understand that:
- I must use a pharmacy approved by the State of Washington Department of Health.
- I must notify PrEP DAP of any changes that affect my eligibility. These changes include address, health insurance coverage and risk conditions. I must send this notice within **20 days** of the change. Failure to do so can lead to eligibility termination.
- PrEP DAP funding is limited. Services may change or end with short notice. Currently, only Truvada® is covered through the program. Truvada® is covered either at full cost (with approval) or co-pay (if insured).
- If I give false or incomplete information PrEP DAP may deny or stop my eligibility. I may have to pay for services I received if I was not eligible for them.
- PrEP DAP will use other state and federal data systems and other information to verify the information I give them.
- I must respond to PrEP DAP requests for information. Failure to do so can lead to eligibility termination or denial.

Release of Information:

I give my permission for PrEP DAP to share information from this application and from documentation obtained by PrEP DAP with contracted providers, pharmacies, case managers, navigators, contracted vendors and family/friends I listed in the Authorized Representative section of this application. I give this permission for one year and 60 days from the date I sign this authorization.

Assignment of Benefits:

I hereby assign to the Washington State Department of Health any right to drug or medical benefits to which I may be entitled under any other plan of assistance or insurance from any other eligible third party. I consent to the assignment of these benefits to the Washington State Department of Health and I understand the Washington State Department of Health is entitled to repayment for incorrectly provided benefits or benefits to which a third party is liable.

_____ _____

Applicant or Legal Guardian Signature **(Do Not Leave Blank)** Today's Date (mm/dd/yyyy) **(Do Not Leave Blank)**